DEPARTMENT OF HEALTH &HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D C 20201

JUL 7 1999

The Honorable Thomas J. Bliley, Jr.
Chairman
Committee on Commerce
United States House of Representatives
Washington, D.C. 20515-0115

Dear Chairman Bliley:

Thank you for your letter of June 15, 1999 inquiring about the Health Care Financing Administration's (HCFA) Medicaid anti-fraud initiatives and our efforts to assist States in combating fraud and abuse within the program. The Administrator has asked me to respond on her behalf. Your letter makes particular reference to the November 1996 Department of Health and Human Services' Office of Inspector General (OIG) report that focused on the issue of State Surveillance and Utilization Review (SURS) units' case development and referrals to the Medicaid Fraud Control Units (MFCUs). You had asked us five specific questions addressing our progress in implementing the recommendations from that report. The responses to those questions are provided as an attachment to this letter.

I would like to address another concern you raise in your letter. You indicate that because the Medicaid program is principally administered by the States, there is a perception, by some, that less attention and focus have been dedicated at the federal level to systematically combat and eliminate fraud within the program, particularly when contrasted with those efforts made in the Medicare program. This perception is regrettable and it would be a mistake to conclude that HCFA is less than fully committed to combating fraud and abuse in the Medicaid program and assuring State accountability.

In Medicaid, HCFA shares the cost and responsibility for administering the program with the States, whereas HCFA is singularly responsible for administering Medicare. Therefore, our role in Medicaid is focused on developing federal policies and providing oversight and assistance to the States which operate the program. Because State Medicaid programs vary greatly and they are on the "front lines," our approach is based on a strong State/federal partnership that allows States flexibility to tailor their fraud and abuse programs to meet their specific needs.

HCFA staff responsible for fraud and abuse activities have spoken with your staff on several occasions over the past few weeks. During those discussions we have highlighted the many activities and initiatives HCFA has undertaken to combat fraud and abuse in the

Medicaid program. I have outlined these activities in our responses to your questions. Let me assure you that HCFA will continue to fulfill its oversight responsibilities, and we will continue to work closely with the States to assist them in their fight against fraud and abuse.

I believe that the actions and accomplishments noted in our responses to your questions, in our discussions with your staff and in the background documentation supplied to your staff, amply demonstrate our commitment to working closely with the States to empower and enable them to fight fraud and abuse in their respective Medicaid programs while, at the same time, assuring that States are held accountable for their results.

If you have any questions about these activities or initiatives or would like to know more about them, please do not hesitate to contact me. I hope you find our responses to your inquiries to be informative and useful.

Sincerely,

Michael M. Hash
Deputy Administrator

Attachment (1)
cc: The Honorable John D. Dingell, Ranking Member

RESPONSES TO QUESTIONS CONCERNING THE OIG'S REPORT

The November, 1996 OIG report focused in large part on the working relationship between SURS units and MFCUs. We view this relationship as an integral part of our efforts to combat fraud and abuse in Medicaid, consequently, we have included the MFCUs in virtually every project and initiative we have undertaken.

Your questions are drawn directly from the first recommendation of the 1996 OIG report. That recommendation was that HCFA convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations and made a number of suggestions about the work such a group could undertake. I am pleased to report that we have made significant progress in implementing this recommendation and in fact have expanded upon it in a number of ways which I will detail below.

Like a predecessor 1989 report, the 1996 report notes the need for a coordinated anti-fraud and abuse effort, with a HCFA focal point for that activity; and for increased technical assistance to the States in combating fraud and abuse.

As we noted in our response to the OIG report, HCFA established the Program Integrity Group in 1996 as a coordinating body to address fraud and abuse issues within the Medicare and Medicaid programs. The next year, in order to more efficiently respond to the unique and specific needs of State Medicaid agencies, HCFA designated the Southern Consortium as the national lead for an intensive Medicaid fraud and abuse initiative, launched with significant support from State Medicaid directors and other State and federal partners. The Southern Consortium consists of HCFA's Atlanta and Dallas regional offices (RO). This represents a significant departure from traditional HCFA central/regional office roles. We did this for two reasons: 1) the regional offices are closer to front line State activities; and, 2) the Atlanta RO, in particular, had a good deal of experience in program integrity, e.g., its role in the South Florida Task Force, the formation of the Miami Satellite Office, Operation Restore Trust, etc. The Dallas RO has since opened a satellite office in New Orleans.

Your questions refer directly to the list of five elements that the OIG had recommended be addressed by the Medicare and Medicaid task force on fraud and abuse. Our detailed responses follow.

However, I want to note that we proceeded with our task force in a slightly different way than that detailed in the OIG recommendation. The actual agenda of our fraud and abuse initiative, and the priorities for work deemed most critical to improving prevention, detection and investigation of fraud and abuse, were set in consultation with State Medicaid agencies. In the end, many of the areas we are focusing on do in fact parallel the subparts of the OIG recommendation. Among other things, we are focusing on (1) training and technical assistance on how to prevent, detect and respond to fraud and abuse, (2) appropriate use of data to identify suspected fraud, (3) identification of particular problems and responses in the managed care and pharmacy environment, and (4) legislative responses to fraud and abuse.

Question #1: Please identify and explain all efforts made to date to develop unified goals and objectives for Medicaid program integrity.

RESPONSE: Since the State/federal partnership is the cornerstone of our strategy, the most effective contribution HCFA can make to the Medicaid anti-fraud effort is through a strong and sustained partnership with the States. We can have the most impact on the Medicaid anti-fraud effort by serving as a facilitator, enabler and, at times, a catalyst for the dissemination and implementation of effective anti-fraud and abuse strategies. Given the States' response to this approach and the feedback we have received thus far, I believe the States agree with our assessment.

At the outset, we convened a focus group in Atlanta with 15 States and HCFA central and regional offices participating. While many issues were discussed, three main themes emerged from the focus group: 1) States wanted HCFA to provide leadership and a national forum for Medicaid fraud and abuse issues, **2)** they wanted HCFA's help in providing a mechanism for better interstate communication and information sharing, and, **3)** they wanted HCFA's help in facilitating Medicare-Medicaid information sharing. Immediately following the focus group, HCFA central and regional office staff met and developed a strategic plan. One outcome of this strategic planning session was to significantly strengthen HCFA's Regional Office Fraud and Abuse Network.

The key activities and outcomes achieved since this initiative was begun are described below:

Medicaid Fraud and Abuse Control Technical Advisory Group **(TAG)**

The Medicaid Fraud and Abuse Control TAG was formed and funded by HCFA to provide the States with a national forum to share information about common issues and approaches to dealing with fraud and abuse. There are twelve States represented on the TAG, as well as representatives from the National Association of MFCUs, the National Association of SURS Officials, and Medicare. The TAG meets regularly and has established a networking system for information exchange. Some of the TAG's activities include:

- development of legislative proposals
- review of regulatory provisions in an effort to facilitate program integrity efforts
- conducted a survey of State Program Integrity directors and MFCU directors to identify major fraud issues
  - developing a best practices guide to prevent pharmacy fraud
  - studying federal fraud and abuse reporting requirements - currently working on an educational packet of available program integrity-related databases
  - working with OIG to develop CFO Act payment accuracy audits
  - developing a "Best Practices" guide that outlines key components for an effective working relationship between State Program Integrity Units (including SURS units) and MFCUs
  - overseeing project to enable States and MFCUs to input Medicaid cases into the Fraud Investigations Database (previously an exclusively Medicare database)
  - formed Medicaid Managed Care Workgroup to address the unique fraud and abuse control issues that exist in the managed care environment

State Legislation Website - Medicaid Fraud Statutes

The RO Medicaid Fraud and Abuse Network is another element of our national initiative to combat and control fraud in the program. One of its projects was to form the State Legislation Database Workgroup, comprised of State Program Integrity directors, State legal staff, MFCU directors, and HCFA central and regional office staff. With input from every State, the Workgroup produced the Medicaid Fraud Statutes Website. The objective was to develop a database which all States could easily access to share innovative and effective State program integrity legislation.

We have received very positive feedback on this project, and it is not only being used by State program integrity staff and MFCUs, but by State legislative staffs and others.

Guidelines for Fraud in Medicaid Managed Care

Another Workgroup just completed a comprehensive report on fraud in Medicaid managed care, which will be provided to States in the form of guidelines. It is currently undergoing review and clearance within HCFA. Once that is done, it will be shared with OIG and DOJ for technical review. Staff from seven State Medicaid agencies, five MFCU Directors, and HCFA central and regional offices participated in this project.

Medicaid Fraud and Abuse Executive Seminars

As part of our national Medicaid Fraud and Abuse Initiative, we contracted with Dr. Malcolm Sparrow of Harvard University's Kennedy School of Government to conduct a series of fraud and abuse executive seminars. We conducted the last of four seminars in May. In keeping with our goal of working in partnership with States, the purpose of these seminars was to provide State decision-makers with tools to develop and implement innovative strategies to better combat fraud and abuse in their respective Medicaid programs. The seminars focused on strategies and solutions.

These seminars were attended by 49 States, the District of Columbia, and three territories. Attendees included State Medicaid directors, State Program Integrity directors, MFCU directors, some representatives from Governors' offices, etc. On the federal side, the seminars were attended by senior officials from HCFA, OIG, DOJ (Main Justice and U.S. Attorneys' Offices), the FBI, and the Administration on Aging. The feedback has been overwhelmingly positive.

Question #2: Please identify and explain all efforts made to date to formulate guidelines for developing suspected Medicaid fraud cases. Please provide copies of any guidelines which have been prepared.

RESPONSE: Each State has procedures for developing suspected fraud cases. Because each State is different, we do not believe that a "one size fits all" approach is productive, as it is in a program like Medicare that is uniform nationwide and does not vary from region to region. What would be suitable in one State, may not be suitable in another. The issue of resource constraints at the State level also comes into play. For these reasons, we would be reluctant to impose one particular method on all States.

As our response to Question #1 indicates, we have been very active in our efforts to improve States' abilities to combat fraud and abuse. States have been receptive to our efforts; consequently, we have experienced significant successes in many areas. We realize there is much more to be done and we will be closely monitoring States' progress. Recognizing that our oversight responsibilities in program integrity are the same as in all other areas of Medicaid, we will address less aggressive and ineffective efforts on the part of States using our normal regulatory authorities.

Additionally, I am not sure there is unanimity on this point even among the various State MFCUs. In the past, some MFCUs have indicated they want the SURS unit or Program Integrity unit to forward cases as soon as that unit suspects fraud, with whatever documentation they have up to that point. In some instances, the MFCU prefers to do much of the case development and investigation itself, as investigative expertise resides in the MFCU. Other MFCUs prefer that the SURS or Program Integrity unit present a highly developed, documented case for its consideration.

We have, however, developed guidelines as part of the comprehensive report on fraud in Medicaid managed care I referred to earlier. While the report deals with many aspects of fraud control in the managed care environment - definitions, case examples, roles of key players, contractual language, components of an effective fraud control program, etc. - it also provides guidelines on prevention, detection, investigation, and referral of suspected fraud cases. Again, this report is currently going through the review and clearance process within HCFA. It will then be shared with OIG and DOJ for technical review before it is released to the States.

We initiated this project because more and more States are moving their Medicaid programs away from traditional fee-for-service to a managed care or capitated environment. However, developing guidelines in the fee-for-service part of the program may be a good project for the Medicaid Fraud and Abuse Control TAG. The TAG could develop a best practices guide and provide it to all States to see if it offers them something better than what is currently being used. This may be a project that would interest the MFCU representative to the TAG.

Question #3: Please identify and explain all efforts made to date to develop a universal protocol for appropriately referring Medicaid fraud and abuse cases. Please provide copies of any protocols that have been developed.

RESPONSE: Again, because State Medicaid programs and State organizational structures vary so widely, we do not believe a universal protocol is workable.

Additionally, in response to the OIG report we collaborated with the National Association of MFCUs and the National Association of SURS Officials to conduct a series of five Fraud in Medicaid Managed Care Workshops.

These workshops brought SURS and MFCU directors together from 49 States, as well as Medicaid managed care program staff. One of the stated goals was for SURS and MFCUs to negotiate ways to work more effectively together. At the conclusion of these workshops, all 49 States in attendance had developed both long-term and short-term agreements. While some were fairly basic, others were more elaborate and detailed.

Question #4: Please identify and explain all efforts made to date to coordinate data systems to insure that data are reliable and consistent across all entities the Medicaid fraud and abuse fighting network.

RESPONSE: We are making a number of efforts in this area. As noted earlier, the TAG formed a Workgroup to study the various federal fraud and abuse reporting requirements, and is currently working on an educational packet of available program integrity-related databases; the MFCU TAG representative is a member of this Workgroup. The TAG is also working with HCFA's Program Integrity Group to revise and expand the Fraud Investigation Database (FID), to enable both Medicaid State agencies and MFCUs to input Medicaid cases into the FID. The Medicaid Fraud Statutes Website provides States with a comprehensive national listing of Medicaid anti-fraud citations.

Finally, the Balanced Budget Act of 1997 eliminated the Systems Performance Review (SPR) requirement which was used, among other things, to evaluate States' fraud and abuse activities through the Medicaid Management Information System. In an effort to provide States with technical assistance in this area, HCFA has formed a Workgroup to develop guidelines and best practices to assist States in performing their SURS function We will also continue our discussions with the TAG on the feasibility of developing a baseline data collection system.

Question #5: Please identify and explain all efforts to date to develop a training program to educate Medicaid program integrity personnel on procedures, case referrals and best practices.

RESPONSE: Given our view that partnering with the States is the most effective approach to Medicaid fraud control, we have been very active in this area. Many of the activities I have outlined demonstrate HCFA's commitment to assisting States in their efforts to apply effective fraud control strategies and programs in their respective programs. Again, we have opted not to adopt one, generic training program; rather, we have taken a multi-faceted approach which includes such things as, the Fraud and Abuse Executive Seminars with Malcolm Sparrow, the Fraud in Medicaid Managed Care Workshops, the Guidelines for Fraud in Medicaid Managed Care, and the guidelines currently being developed for SURS units.